Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004028	A. BUILDING: _____ B. WING _____	06/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK HOUSE	725 W 50TH ST MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: June 13, 14, 2013 Facility number: 004028 Provider number: 004028 AIM number: N/A Survey team: Betty Retherford RN, TC Linn Mackey RN Shelley Reed RN (6/13/13) Angela Selleck RN Census bed type: Residential: 42 Total: 42 Census payor type: Other: 42 Total: 42 Sample: 7 York House was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality Review 06/141/3 by Lisa McColly	R 000		